MAPB-087-015-D/002-HA
Date: 9/1/87

Attachment B-7

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IMA		1234567890	1

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, M.S.	12345678	(XXX) XXX . XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING

A. Requesting: ☐ Physical Therapy ☐ Occupational Therapy ☒ Speech Therapy (AUDIOLOGY)

B. Total time per day requested: 2-3 hours
   Total Sessions per week requested: 1
   Total number of weeks requested: 1

C. Provide a description of the recipient's diagnosis and problems and date of onset.

HEARING DEFICIT

D. Brief Pertinent History:

SEIZURES IN NEONATAL PERIOD
INTERCRANIAL BLEED

	Location	Date	Problem Treated

E. Therapy History

PT

OT

SP

PHENOBARBITAL

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

NEEDS AUDITORY EVOKE POTENTIAL

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized.

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

I. **Rehabilitation Potential:**

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. M.D. Prescribing — Signature of Prescribing Physician (A copy of the Physician's order sheet is acceptable)

M.D. Performing — Signature of Therapist Providing Treatment

MM/DD/YY
Date

MM/DD/YY
Date